Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: DOCTORS HOSPITAL A RENAISSANCE 5501 S MCCOLL EDINBURG TX 78539	MFDR Tracking #: M4-11-1149-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: PREFERRED PROFESSINAL INSURANCE CO Rep Box #: 01	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TDI Guidelines."

Amount in Dispute: $88.40

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Respondent did not submit a response to this dispute.

Response Submitted by: N/A

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
06/16/2010	Hospital Outpatient Services	Not Applicable	$88.40	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled *Hospital Facility Fee Guideline – Outpatient***,** effective for medical services provided on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   Explanation of benefits dated 07/22/2010 noted claim reduction codes:
   - W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - 97 — PAYMENT IS INCLUDED I THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.

   Explanation of benefits dated 08/18/2010 noted claim reduction codes:
   - 193 — ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.

2. Division rule at 28 TAC §134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables."

3. Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall

be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."

4. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:
   (1) No documentation was found to support a contractual agreement between the parties to this dispute;
   (2) MAR can be established for these services; and
   (3) The submitted documentation does not support that the provider requested separate reimbursement for implantables with the billing.
5. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.
6. For this date of service, the requestor billed CPT codes 72194, 74170 and Q9967. The requestor lists CPT code 72194 as the code in dispute.
7. CPT code 72194, is a Status S code which is defined as "outpatient significant procedure NOT subject to multiple procedure discounting." CPT codes 74170 and Q9967 are Status N codes which is defined as "services or procedures included in the APC rate, but NOT paid separately. (This is a packaged item)."
8. Reimbursement for this outpatient service pursuant to 28 TAC§134.403(f) is as follows: $584.94 (APC) + $0.00 (outlier amount) = $584.94 x 200% = $1,169.88 (MAR).
9. The respondent issued reimbursement for $1,169.88. No additional reimbursement is allowed for this hospital outpatient service.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031, §413.0311
28 TAC §133.305, §133.307, §134.403

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	**08/31/2011** Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.